



MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023251

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 723

FILED JUN 19 1963

VS 300
Rev. 4/59

1 5117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

R.W. Kieber, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph,</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>St. Joseph,</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1804 Karlov St. Goforth Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>625 Roy Street</u>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>E.</u> Last <u>AMOS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railway Co. K.C. & St. Joseph,</u>	11. BIRTHPLACE (City and state or country) <u>New Point, Missouri</u>
13a. FATHER'S NAME <u>John F. Amos</u>		13b. MOTHER'S MAIDEN NAME <u>Delana Lentz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		17. INFORMANT <u>Nephew</u> Address <u>Mr. Vincent Bumbacher, St. Joseph, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Abd. Malignancy</u> <u>(Origin Prostate)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III: If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1-1-63</u>		20f. CITY, TOWN, OR LOCATION <u>St Joseph, Mo</u>	
21. I attended the deceased from <u>6:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS <u>St Joseph, Mo</u>	
22a. SIGNATURE <i>Robert W. Kieber, M.D.</i>		22c. DATE SIGNED <u>6-13-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 14, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>June 17, 1963</u>	
26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued 6-13-63

2112
2112

0 0 0 0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

0-28

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4677

P. O. Address 3703 1/2 St. N.W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.